



Horizon Blue Cross Blue Shield of New Jersey

Dispensing Limit Program Exception Request Form

To initiate a medical necessity and appropriateness review, complete this form in its entirety and fax it to **1-973-274-2285**.

If you have questions, please call CVS Caremark's Prescription Service at **1-866-881-5603**, Monday through Friday, between 9 a.m. and 5 p.m., Eastern Time (ET).

Date: _____

Patient Information:

Name: _____

DOB: _____

ID #: _____

Gender: Male Female

Requested Medical Information:

Drug Name and Strength: _____

Quantity: _____

Expected Duration of Therapy: _____

Directions: _____

Patient's Diagnosis: _____

Has the patient previously received this medication? Yes No

If yes, how long has the patient been treated with this medication? _____

Please provide clinical information to support prescribing this medication in quantities that exceed the recommended allowances or are outside of the Dispensing Limit parameters. Attach any supporting documentation, including chart notes or letters, indicating the outcome of this medication when used within the dispensing limit and the results of previous trials of therapeutic alternatives.

Prescriber Information:

Prescriber's Name: _____

Telephone Number: _____

Address: _____

Fax Number: _____

DEA #: _____

Prescriber's Specialty: _____

Nurse or Contact Name: _____

Prescriber's Signature: _____

FOR OFFICE USE ONLY:

Approved / Duration _____

Denied

Additional Comments:

